ambetter. FROM coordinated care™

SUBMIT TO
Utilization Management Department
1145 Broadway, Suite 700
Tacoma, WA 98402
PHONE: 1.877.644.4613
FAX 1-833-286-1086

PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

*All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.

Please indicate which level of care the member is currently engaged: ☐ INPATIENT ☐ OUTPATIENT

IDENTIFYING INFORMATION

Member Name _____ DOB _____ SSN _____

Member ID # _____ Health Plan Name _____

Provider Name _____ OR Agency/Group Name _____

Professional Credentials _____

Provider Phone # _____ Fax # _____

Address (street/city/state) _____

NPI # _____ Tax ID # _____

Referral Source _____

DIAGNOSIS (PLEASE REPORT ALL DIAGNOSES BEING CONSIDERED FOR THIS MEMBER)

Primary (Required) _____ R/O _____ R/O _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Danger to Self or Others (If yes, please explain)? ❑ Yes ❑ No _____

_____

MSE Within Normal Limits (If no, please explain)? ❑ Yes ❑ No _____

_____

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

❑ Anxiety	❑ Psychosis/Hallucinations	❑ Eating disorder symptoms	❑ Inattention
❑ Depression	❑ Inexplicable Behavior	❑ Poor academic performance	❑ Hyperactivity
❑ Withdrawn/poor social interaction	❑ Unprovoked agitation/agressiono	❑ Behavior problems at home	❑ Other _____
❑ Mood instability	❑ Self-injurious Behavior	❑ Behavior problems at school	_____

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way?

_____

_____

_____

_____

_____

_____

_____

MEMBER HISTORY

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past? ❑ Yes ❑ No

Comments _____

_____

SUBMIT TO
Utilization Management Department
1145 Broadway, Suite 700
Tacoma, WA 98402
PHONE: 1-877-644-4613
FAX 1-833-286-1086

Does the patient have a family history of psychiatric disorders, behavior problems or substance use? ❑ Yes ❑ No ❑ Uncertain

Comments _____

_____

Is there any known or suspected history of physical or sexual abuse or neglect? ❑ Yes ❑ No ❑ Uncertain

Comments _____

_____

If ADHD is a diagnostic rule out, please complete the following: Is the patient's presentation on intake consistent with ADHD? ❑ Yes ❑ No

Indicate the results of Conner's or similar ADHS rating scales, if given: ❑ Positive ❑ Negative ❑ Inconclusive ❑ N/A

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, results of school standardized testing) _____

_____

Date of Diagnostic Interview _____

Has the patient had a Psychiatric Evaluation? ❑ Yes ❑ No If yes, date of the interview _____

Previous Psychological Testing? ❑ Yes ❑ No If yes, date? _____

Basic Focus and Results _____

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber _____ ❑ Psychiatrist ❑ General Practitioner ❑ Other

Medication Name	Date Started	Compliant? (Y/N)

REQUEST FOR AUTHORIZATION

Please check only one code:

Psych Testing:

❑ 96101 ❑ 96102 ❑ 96103

NeuroPsych Testing:

❑ 96116 ❑ 96118 ❑ 96119 ❑ 96120

Aphasia Assessment: ❑ 96105

Developmental Testing:

❑ 96110 ❑ 96111 ❑ 96125

Please list the tests planned to answer the clinical questions.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Number of units/hours requested to complete tests: _____

Provider Name _____

Provider Signature _____ Date _____

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

Testing instruments to be used _____

_____